U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 19 August 2004

IN THE MATTER OF:

JACKIE W. CLENDENON,
Claimant,

v. Case No.: 1996-BLA-1194

WESTMORELAND COAL CO.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

DECISION AND ORDER ON REMAND AWARDING LIVING MINER'S BENEFITS

On October 6, 2003, the Benefits Review Board (Board) issued a *Decision and Order* vacating the Administrative Law Judge's July 24, 2002 *Decision and Order* on second remand.

In compliance with the Board's directive, an *Order of Reassignment on Remand and Requesting Briefs* was issued by the undersigned on April 16, 2004. The parties have been notified that a decision will be rendered by the undersigned after consideration of the Board's *Decision* as well as the evidence of record and briefs submitted by the parties on remand.

Initially, it is noted that the prior Administrative Law Judge found that the chest x-ray evidence was preponderantly negative such that Claimant did not sustain his burden of establishing the presence of pneumoconiosis under 20 C.F.R. § 718.202(a)(1) (2001). On the other hand, the Judge concluded that the pulmonary function study and blood gas study evidence preponderantly yielded qualifying values, even after administering bronchodilators during pulmonary function testing. Further, he determined that the miner established (1) 27 years of coal mine employment, ending in 1995, and (2) he smoked one pack of cigarettes per day for 30 years, quitting in 1986. In addition, the Judge found that Dr. Forehand relied on an accurate smoking history in rendering his opinion that the miner's tobacco abuse and coal dust exposure contributed to his disabling respiratory impairment. All of the foregoing findings have been

affirmed by the Board. With regard to the issues to be considered on remand, the Board has directed the following:

· the opinions of Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino must be reconsidered under 20 C.F.R. § 718.204(a)(4) (2001) as they diagnosed the presence of a smoking-induced respiratory impairment based on the fact that fibrosis was not discernable on chest x-rays and that the miner's pulmonary function testing demonstrated reversibility, which is inconsistent with a finding of an irreversible, progressive disease such as coal workers' pneumoconiosis;

· the opinions of Drs. Fino and Tuteur must be reconsidered under 20 C.F.R. § 718.204(a)(4) (2001) on grounds that they cite to extensive literature in support of their conclusions that the miner's respiratory impairment is due solely to tobacco abuse;

· it was improper to discredit the opinions of Drs. Fino, Tuteur, Dahhan, Sargent, Morgan, and Castle for failure to consider the presence of legal pneumoconiosis; rather, the Board noted that these physicians did consider, and ruled out, the presence of legal coal workers' pneumoconiosis;

· the qualifications of the physicians must be considered on remand when weighing their opinions;

· all evidence under 20 C.F.R. § 718.202(a)(1) and (a)(4) (2001) must be weighed together to determine whether the miner suffers from coal workers' pneumoconiosis pursuant to *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000);

· the medical evidence must be reconsidered under 20 C.F.R. § 718.204(c) (2001) to determine whether the miner's totally disabling respiratory impairment was caused, in part, by coal workers' pneumoconiosis and, in particular, whether Dr. Paranthaman's opinion that, "[i]f 27 years of coal mine employment is documented, it could have aggravated the condition significantly," is too equivocal to support causation; and

· the onset date must be reconsidered.

I
Medical opinion evidence under 20 C.F.R. § 718.202(a)(4) (2001)

Claimant may establish that the miner suffered from coal workers' pneumoconiosis by well-reasoned, well-documented medical reports under 20 C.F.R. § 718.202(a)(4) (2001). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

Summary of the medical opinion evidence

All of the examining and consultative physicians of record conclude that the miner suffered from a totally disabling respiratory impairment. Drs. Forehand and Paranthaman conclude that this respiratory impairment was due to the miner's coal mining and smoking histories. The remaining physicians, Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino conclude that the miner did not suffer from coal workers' pneumoconiosis and his respiratory impairment was due to his tobacco abuse as well as complications from obesity and hypertension.

Summaries of the medical opinions contained in the judge's decisions of October 14, 1997, September 22, 1999, and July 24, 2002 *Decisions* are hereby incorporated by reference in this *Decision* and supplemented as follows:

A. Dr. A. Dahhan

Dr. Dahhan examined and tested the miner and issued a report on April 10, 1996. He also reviewed certain medical records and issued a subsequent report on January 24, 1997. Dr. Dahhan reported a 27 year coal mine employment history as well as a 30 pack year history of smoking cigarettes. Examination of the lungs revealed reduced air entry to both lungs, bilateral expiratory wheezes, and a prolonged expiratory phase. A chest x-ray was read as negative for the presence of pneumoconiosis. Pulmonary function and blood gas testing revealed a respiratory impairment that was partially reversible with use of a bronchodilator. Dr. Dahhan noted his disagreement with Dr. Forehand's conclusion that the miner suffered from coal dust and smoking-induced pulmonary disability "because when (Dr. Dahhan) examined him, (the miner) demonstrated significant reversibility with the administration of bronchodilators" and that "[t]his is a finding that is inconsistent with the adverse affects of coal dust on the respiratory system." Dr. Dahhan further opined that the miner did not have any exposure to coal dust for more than 12 months, which "is sufficient to cause cessation of any industrial bronchitis that he may have had." Moreover, Dr. Dahhan noted that the miner did not suffer from complicated pneumoconiosis or progressive massive fibrosis "which could cause secondary obstructive ventilatory abnormality."

Dr. Dahhan was deposed on September 23, 1996. *Dx.* 10. He stated that the miner suffered from smoking-induced obstructive lung disease and opined that coal dust exposure did not contribute to the respiratory impairment because the spirometry revealed purely obstructive

findings, there was some reversibility after use of a bronchodilator, and the chest x-ray findings were negative for coal workers' pneumoconiosis.

Dr. Dahhan reviewed certain medical records and issued a second supplemental report on February 7, 1997. He reiterated his earlier findings and diagnoses. Dr. Dahhan opined that, even if the miner suffered from radiological evidence of simple coal workers' pneumoconiosis, he would continue to conclude that his respiratory impairment was related only to tobacco abuse.

B. Dr. J. Dale Sargent

Dr. Sargent examined and tested the miner and issued a report on January 27, 1997. He noted a 27 year history of coal mine employment as well as a 30 year history of smoking less than one pack of cigarettes per day. Examination of the lungs revealed slightly decreased breath sounds with crackles at the lower left lung base that cleared only partially with deep breathing. A chest x-ray produced negative results. Pulmonary function testing revealed emphysema and bronchospasm. Blood gas testing yielded abnormal results. Dr. Sargent concluded that the miner "is undoubtedly suffering from a disabling respiratory impairment." He noted that, even after application of a bronchodilator, the miner had an FEV1 of approximately 40% of the predicted value and he suffered from resting hypoxemia that worsened with exercise.

Dr. Sargent opined that the miner's respiratory impairment was due solely to obstructive lung disease arising from tobacco abuse. He explained that coal workers' pneumoconiosis causes a mixed restrictive and obstructive impairment that does not respond to bronchodilator therapy. Further, Dr. Sargent stated that "when coal workers' pneumoconiosis does cause a ventilatory impairment it does so in the face of an x-ray which shows the characteristic changes for coal workers' pneumoconiosis." Dr. Sargent notes that tobacco abuse causes a purely obstructive impairment, which may respond to a bronchodilator. Dr. Sargent states the following:

> In this case, Mr. Clendenon has a partially reversible, purely obstructive ventilatory impairment (restriction is excluded by a normal total lung capacity and elevated residual volume). Therefore, his impairment is completely consistent with an impairment due to cigarette smoking and not consistent at all with impairment due to coal dust exposure.

Dr. Sargent was deposed on February 26, 1997. *Ex.* 25. He reiterated that the miner suffered from smoking-induced obstructive lung disease. *Ex.* 25 at 23. Dr. Sargent cited to preponderantly negative chest x-ray findings and the fact that the miner demonstrated obstruction without restriction on pulmonary function testing in support of his diagnosis. Dr. Sargent further testified that the miner exhibited a 31 percent improvement in the FEV1 after use of a bronchodilator, which indicated the presence of an asthmatic component to his disease. *Ex.* 25 at 25. Dr. Sargent was asked to explain the distinction between medical and legal pneumoconiosis and he stated the following:

> [M]edical pneumoconiosis is a very strictly-defined term used to define the constellation of chest x-ray changes and pulmonary function tests that are seen classically with pneumoconiosis.
>
> The legal definition of coal workers' pneumoconiosis is any disease of the lung caused by or substantially aggravated by exposure to coal dust and includes other diseases, such as industrial bronchitis, that are not classically considered coal workers' pneumoconiosis.

Ex. 25 at 26. When asked whether the miner suffered from legal pneumoconiosis, Dr. Sargent replied, "He doesn't have any evidence of any impairment due to coal dust exposure, he doesn't have chronic bronchitis, and he doesn't have medical classical pneumoconiosis." *Ex.* 25 at 26.

C. Dr. Gregory Fino

Dr. Fino has conducted reviews of certain medical records and issued reports on June 27, 1996 and February 6 and 10, 1997. He noted a 30 year coal mine employment history as well as a 30 pack year history of smoking cigarettes. Dr. Fino concluded that the miner suffered from significant emphysema and significant chronic obstructive lung disease arising from his smoking history. In his February 6, 1997 report, Dr. Fino offers this conclusory opinion:

> Please note that I would preface all this by stating that coal mine dust inhalation certainly can cause an obstructive ventilatory abnormality. However, in each and every case one must assess whether the changes are consistent with coal mine dust, smoking or both. In this particular case there is no doubt in my mind that the changes are related to smoking. Finally, I would point out that even if this man were found to have a coal mine dust related pulmonary condition, I would find him as disabled had he never stepped foot on the coal mines.

In his February 10, 1997 report, Dr. Fino reiterated that the obstructive abnormality on spirometry was indicative of a smoking-induced lung impairment as the "obstructive abnormality has occurred in the absence of any interstitial abnormality." He further stated that the small airway flow was more reduced that the miner's large airway flow, which was inconsistent with a coal dust related condition. Dr. Fino stated the following:

> Minimal obstructive lung disease has been described in working coal miners and has been called industrial bronchitis.
>
> . . .
>
> Industrial bronchitis resolves within six months of leaving the mines. Obstructive lung disease may also arise from coal workers' pneumoconiosis when significant fibrosis is present. The fibrosis results in the obstruction. In this case, although obstruction can be seen in coal workers' pneumoconiosis, the obstruction is unrelated to coal mine dust exposure.

Dr. Fino further noted that the miner exhibited some "reversibility" after use of a bronchodilator on pulmonary function testing, which further militated against a finding of coal workers' pneumoconiosis. He also noted an impairment in oxygen transfer consistent with cigarette smoking.

D. Dr. Peter Tuteur

Dr. Tuteur reviewed certain medical records and issued a report on February 6, 1997. He reported a 27 year history of coal mine employment as well as 41 year history of smoking one and one-half a pack of cigarettes per day. Dr. Tuteur noted that, even lesser estimates of the miner's smoking history put him at risk for the development of obstructive lung disease. Dr. Tuteur concluded that there was "no convincing evidence to indicate the presence" of coal workers' pneumoconiosis. He opined that "[a]ll symptoms are fully explained by the presence of advanced chronic obstructive pulmonary disease, predominantly manifested by emphysema" and these conditions are not related to coal dust exposure. Dr. Tuteur concluded that the miner was totally disabled due to his smoking-induced respiratory impairment. Dr. Tuteur reviewed additional medical records and issued a supplemental report on February 7, 1997 wherein he reiterated his earlier findings and conclusions.

Dr. Tuteur was deposed on February 17, 1997. *Ex.* 24. He reiterated that the miner suffered from chronic obstructive pulmonary disease due to smoking-induced pulmonary emphysema. *Ex.* 24 at 11. When asked to explain the basis for his conclusion, Dr. Tuteur stated that the miner's physical symptoms of breathlessness, coughing, and certain breath sounds were compatible with respiratory ailments arising from smoking and/or coal dust exposure. On the other hand, Dr. Tuteur asserted that these symptoms "waxed and waned," which was not consistent with an irreversible disease process such as coal workers' pneumoconiosis. He further noted that the impairment of gas exchange is consistent with the presence of both smoking-induced emphysema and coal workers' pneumoconiosis. *Ex.* 24 at 14. However, Dr. Tuteur noted that hyperinflated lungs and obstruction, without evidence of restriction, "points against coal workers' pneumoconiosis." *Ex.* 24 at 14. Finally, Dr. Tuteur cited to the preponderantly negative chest x-ray readings to confirm the absence of coal workers' pneumoconiosis.

Dr. Tuteur agreed with Dr. Forehand that the miner suffered from severe chronic obstructive pulmonary disease, but Dr. Tuteur concluded that it was due solely to cigarette smoking:

> There is no doubt that progressive massive fibrosis, a coal-mine-dust-induced disease process, can produce both airways obstruction and arterial hypoxemia. But there is absolutely not a shred of evidence to indicate that he has progressive massive fibrosis or conglomerate pneumoconiosis or complicated pneumoconiosis, all terms of which are synonymous.
>
> If one wants to imply that simple coal workers' pneumoconiosis, which I find no evidence for in this data set, or coal mine dust exposure, for which there is clearly

> evidence, can cause an obstructive ventilatory defect, I think it is appropriate to go to the peer review medical literature and carefully and critically review those studies which purport to make that relationship. In my view, having carefully and critically reviewed this literature, none of the studies, even those most often cited from the better journals, make that case in a satisfactory manner.
>
> . . .
>
> On this basis, I strongly disagree with Dr. Forehand's conclusion. He is correct that many of the abstracts and many of the conclusions of these papers do indicate that coal mine dust is associated with a fall in the FEV1; however, the fall is an age-related fall not due to coal mine dust exposure, but when accelerated, due to tobacco smoke inhalation.

Ex. 24 at 19-20.

E. Dr. K.W. Morgan

By report dated August 3, 1996, Dr. Morgan conducted a review of certain medical records and issued his opinion. *Ex.* 4. He reported a 27 year coal mine employment history as well as an extensive smoking history. Based on the medical data reviewed, Dr. Morgan concluded that the miner suffered from "severe airways obstruction, which to all intents and purposes, is irreversible." He further opined that the miner's "blood gas abnormalities were partly a consequence of his chronic airflow limitation, but were almost certainly made worse by the fact that he was markedly overweight." Dr. Morgan attributed the miner's respiratory impairment to tobacco abuse. Citing to negative chest x-ray studies, Dr. Morgan concluded that coal workers' pneumoconiosis was not present. He stated that the miner's emphysema did not arise from coal dust exposure stating "[f]ocal emphysema which occurs in those who have simple CWP is not seen in those who have no radiographic evidence of CWP." Moreover, according to Dr. Morgan, coal dust-induced focal emphysema does not cause airways obstruction. Dr. Morgan concluded that, even if coal workers' pneumoconiosis was present, it would not have contributed to the miner's disability.

F. Dr. James Castle

Dr. Castle reviewed certain medical records and issued reports on September 10, 1996 and February 12, 1997. He concluded that the miner suffered from a totally disabling respiratory impairment unrelated to coal dust exposure. Dr. Castle reported a minimum 45 pack year history of smoking cigarettes and opined that, out of a total of 27 years of coal mine employment, the miner spent only six years engaged in underground mining. Dr. Castle stated the following:

> This is a minimal period of time and certainly if that period of time had caused him to develop abnormalities that led to impairment with coal workers' pneumoconiosis, it is certainly extremely likely that his x-ray would have shown those abnormalities.

Dr. Castle further noted that the miner did not exhibit any physical findings consistent with the presence of coal workers' pneumoconiosis such as rales, crackles, or crepitations. He also stated that the miner exhibited reversibility on pulmonary function testing, which would not be expected if he suffered from coal workers' pneumoconiosis. Dr. Castle further noted that pulmonary function testing did not reveal any restriction, which further indicated the absence of coal workers' pneumoconiosis. Dr. Castle concluded that, even if it was established that the miner suffered from coal workers' pneumoconiosis based on the chest x-ray evidence, the disease did not contribute to his respiratory impairment.

Dr. Castle was deposed on October 2, 1996. *Dx.* 11. He testified that the miner suffered from "severe obstructive airways disease" that he would "classify as being partially reversible." In particular, Dr. Castle found "evidence of pulmonary emphysema with some degree of reversibility" and he concluded that "these conditions (were) totally related to (the miner's) long and extensive history of tobacco abuse." *Dx.* 11 at 7-8. Dr. Castle noted that coal workers' pneumoconiosis was not reversible and the miner did not demonstrate any restriction on pulmonary function testing; rather, "[t]his is pure obstruction consistent with tobacco smoke-induced pulmonary emphysema." *Dx.* 11 at 9. Dr. Castle maintained that the miner's pulmonary emphysema was unrelated to coal dust exposure. To the contrary, Dr. Castle concluded that the miner suffered from centrilobular emphysema arising from coal dust exposure. Dr. Castle explained his findings as follows:

> This man did not have any physical findings indicating coal workers' pneumoconiosis, and he did not have any x-ray findings of coal workers' pneumoconiosis, none whatsoever. His physiologic testing is not consistent with coal workers' pneumoconiosis, in that he had a pure obstructive, significantly reversible obstructive defect with a reduction in diffusing capacity, and I would comment at this point that his forced vital capacity improved 30 percent.
>
> That is a very significant degree of improvement. He did not have the arterial blood gas findings that would go along with this disease process, and by that I mean that his PO2 did not fall significantly with exercise. When somebody has hypoxemia related to coal workers' pneumoconiosis, they will have a fall in the PO2 with exercise and that did not occur.
>
> He should not have had an elevation of his PCO2, and it was elevated, so all of these things together allow me to arrive at the diagnosis of tobacco smoke-induced pulmonary emphysema with a significant degree of reversibility, and I can separate that out from changes related to coal workers' pneumoconiosis.

Dx. 11 at 14-15.

G. Dr. J. Randolph Forehand

Dr. Forehand examined and tested the miner on November 13, 1996 and issued a report. *Cx.* 1. He noted a 27 year coal mine employment history as well as a 30 pack year history of smoking cigarettes. Dr. Forehand found that a chest x-ray demonstrated the presence of coal workers' pneumoconiosis and spirometry yielded evidence of an irreversible obstructive ventilatory pattern. Dr. Forehand diagnosed the miner with chronic obstructive pulmonary disease, coal workers' pneumoconiosis, and evidence of atherosclerotic cardiovascular disease.

Dr. Forehand issued a supplemental report on November 17, 1996. He concluded that smoking and coal dust exposure contributed to the miner's respiratory impairment. Citing to recent medical literature, Dr. Forehand posited that coal dust exposure and smoking cause chronic obstructive pulmonary disease.

H. Dr. S.K. Paranthaman

Dr. Paranthaman examined and tested the miner and issued a report on November 16, 1995. *Dx.* 14. He noted 27 years of coal mine employment as well as a 25 year history of smoking one and one-half a pack of cigarettes per day. Examination of the lungs revealed that breath sounds were moderately decreased bilaterally and the AP diameter of the chest was increased. Blood gas and pulmonary function tests yielded qualifying values. A chest x-ray was interpreted as negative for the presence of coal workers' pneumoconiosis. Dr. Paranthaman diagnosed the presence of pulmonary emphysema and essential hypertension. He further noted the following:

> Pulmonary emphysema is primarily due to heavy cigarette smoking . . .. If 27 years of coal mine employment is documented, it could have aggravated the condition significantly.

Dr. Paranthaman concluded that the miner was totally disabled due to pulmonary emphysema.

By supplemental report dated January 19, 1996, Dr. Paranthaman diagnosed the presence of legal coal workers' pneumoconiosis stating that, while the miner's tobacco abuse was the primary cause of his pulmonary emphysema, the miner's lengthy coal dust exposure also contributed to development of the condition.

Discussion and conclusions

The record establishes that the miner had a 30 pack year history of smoking cigarettes, ending in 1986, and he had 27 years of coal mine employment, where he worked until 1995. All of the physicians of record conclude that he suffers from a severe, totally disabling chronic obstructive lung disease. Claimant developed shortness of breath while working as a coal miner and his respiratory impairment worsened while he continued to work, even after he ceased smoking.

Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino conclude that the miner's respiratory impairment is solely due to his history of tobacco abuse. Each of these physicians cites to one or more of the following reasons for their diagnoses: (1) preponderantly negative chest x-ray findings; (2) spirometry demonstrating pure obstruction without restriction; (3) citation to certain medical studies that purport to establish that coal workers' pneumoconiosis does not cause centrilobular emphysema or obstructive lung disease in the absence of findings of complicated pneumoconiosis; and (4) partial reversibility on pulmonary function testing. Moreover, Drs. Dahhan, Fino, Tuteur, Morgan, and Castle offered cursory conclusions that, even if Claimant established that he suffered from coal workers' pneumoconiosis, the disease did not contribute to his disability.

Clinical pneumoconiosis not established; negative chest x-rays

The prior judge found, and the Board affirmed, that a preponderance of the chest x-ray evidence was negative for the presence of pneumoconiosis. Therefore, the reports of Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino are well-documented and in accord with the chest x-ray evidence of record with respect to their findings of no clinical coal workers' pneumoconiosis. However, the inquiry does not end here.

The provisions at 20 C.F.R. § 718.202(a)(4) (2001) provide that "[a] determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative chest x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201." In *Cannelton Industries, Inc. v. Director, OWCP [Frye]*, Case No. 03-1232 (4th Cir. Apr. 5, 2004)(unpub.)[1], the Fourth Circuit recently concluded that an opinion finding no pneumoconiosis based on negative chest x-ray evidence was entitled to little probative value. In *Frye*, Dr. Forehand found that the miner was totally disabled due to smoking-induced chronic bronchitis, but failed to explain "how he eliminated (the miner's) nearly thirty years of exposure to coal mine dust as a possible cause" of the bronchitis. The court noted that "Dr. Forehand erred by assuming that the negative x-rays (underlying his opinion) necessarily ruled out that (the miner's) bronchitis was caused by coal mine dust . . .." As a result, Claimant has not established that the miner suffered from *clinical* coal workers' pneumoconiosis, but it must be determined whether he suffered from *legal* coal workers' pneumoconiosis.

Legal pneumoconiosis established

In assessing whether legal pneumoconiosis is present, the Board directed that the opinions of Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino be reconsidered on the following grounds: (1) they diagnosed the presence of smoking-induced respiratory impairment based on the fact that fibrosis was not discernable on chest x-rays and the miner's pulmonary function testing demonstrated reversibility; (2) their opinions are based on citation to extensive literature that an obstructive respiratory impairment is caused by tobacco abuse; and (3) their qualifications.

[1] A copy of the Fourth Circuit's unpublished decision is attached to this opinion.

Initially, the undersigned notes that the physicians' emphasis on negative chest x-ray evidence and obstructive nature of the miner's impairment establishes that they are focused on *clinical*, rather than *legal*, pneumoconiosis. Thus, to the extent that Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino conclude that the miner does not suffer from legal pneumoconiosis based on such data, their opinions are neither well-reasoned nor well-documented. By recent decision in *Consolidation Coal Co. v. Director, OWCP [Swiger]*, Case No. 03-1971 (4th Cir. May 11, 2004)(unpub.)[2], the Fourth Circuit found similar opinions lacking in probative value:

> Four out of the five physicians whom the ALJ discredited concluded that Swiger did not have pneumoconiosis because his impairment was obstructive in nature, despite the fact that legal pneumoconiosis may consist of an obstructive impairment. For example, Dr. Renn says that coal dust exposure would not cause an 'obstructive ventilatory defect.' (citation omitted). Dr. Rosenburger says that 'clinically significant obstructive lung disease . . . is not associated with coal mine dust exposure'; . . . Dr. Fino says that Swiger's symptoms demonstrate 'obstructive lung disease . . . [which] is not a pattern consistent with the contraction of lung tissue due to fibrosis as would be expected in simple coal workers' pneumoconiosis.
>
> . . .
>
> These comments support the ALJ's findings that the employer's physicians were overwhelmingly focused on clinical rather than legal pneumoconiosis.

See also Cornett v. Benham Coal Co., 227 F.3d 569 (6th Cir. 2000). In this case, even Dr. Sargent acknowledged that chest x-rays and pulmonary function studies were used to determine the presence of clinical pneumoconiosis, and not necessarily the presence or absence of a broader class of ailments defined as "legal" pneumoconiosis. Therefore, to the extent that Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino rely on negative chest x-ray evidence and the obstructive nature of the miner's impairment to discount the presence of legal coal workers' pneumoconiosis, their opinions are not persuasive.

Moreover, citation to various articles, which purportedly stand for the proposition that smoking, and not coal dust exposure, causes obstructive lung disease and centrilobular or pulmonary emphysema is not persuasive. To the contrary, Fourth Circuit precedent and the Department of Labor's position in the regulatory amendments provide that coal workers' pneumoconiosis may cause purely obstructive lung disease. 20 C.F.R. § 718.201(a)(2) (2001); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995). As a result, these physicians' apparent disagreement with this premise entitles their reports to less probative weight. Notably, the Seventh Circuit, in *Freeman United Coal Mining Co. v. Summers*, 272 F.3d 473 (7th Cir. 2001), accorded less weight to Dr. Fino's opinion where it contradicted the findings of the Department during its rulemaking proceedings:

---

[2] A copy of the Fourth Circuit's unpublished opinion is attached to this decision.

> Dr. Fino stated in his written report . . . that 'there is no good clinical evidence in the medical literature that coal dust inhalation in and of itself causes significant obstructive lung disease.' (citation omitted). During a rulemaking proceeding, the Department of Labor considered a similar presentation by Dr. Fino and concluded that his opinions 'are not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature.'

Thus, to the extent that physicians in this claim rely on certain literature to support their position that coal workers' pneumoconiosis does not cause a purely obstructive impairment, their opinions are contrary to the generally accepted view of the medical community as set forth by the Department and their opinions are less reliable.

Similarly, a premise that coal workers' pneumoconiosis does not cause centrilobular or pulmonary emphysema is also contrary to the Department's findings during its rulemaking proceedings. Specifically, some physicians in this claim posit that, while coal dust exposure causes focal emphysema, this form of emphysema does not manifest symptoms. On the other hand, they maintain that tobacco abuse causes centrilobular emphysema, which does manifest symptoms. In its comments to the amended regulations, the Department takes a contrary position in this regard and states the following:

> Drs. Fino and Bahl find no scientific support that clinically significant emphysema exists in coal miners without progressive massive fibrosis . . ., but the available pathologic evidence is to the contrary.
>
> . . .
>
> Centrilobular emphysema (the predominant type observed) was significantly more common among the coal workers. The severity of the emphysema was related to the amount of dust in the lungs. These findings held even after controlling for age and smoking habits.

65 Fed. Reg. 79,942 (Dec. 20, 2000).

The general premise, that simple coal workers' pneumoconiosis does not cause a purely obstructive impairment or does not cause pulmonary or centrilobular emphysema, is contrary to the position of the Department and Fourth Circuit. Consequently, the reports of Drs. Dahhan, Sargent, Tuteur, Morgan, Castle, and Fino, to the extent they rely on this contrary premise, are less probative. *See Bethenergy Mines, Inc. v. Director, OWCP [Rowan]*, Case No. 01-2148 (4th Cir. Sept. 4, 2002) (unpub.) (the court upheld an administrative law judge's finding that centrilobular emphysema was caused by the miner's smoking and coal dust exposure) [3]; *Knizer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985) (a medical opinion based on generalities, rather than specifically focusing on the miner's condition, may be accorded less weight).

[3] A copy of the Fourth Circuit's unpublished decision is attached to this opinion.

Finally, as noted by the Board, some physicians note reversibility on the miner's pulmonary function testing after use of a bronchodilator to discount the presence of a coal dust-induced impairment, which is a progressive and irreversible condition. In this case, however, the record demonstrates that the miner's overall respiratory impairment deteriorated over time and his ventilatory function was only partially reversible after use of a bronchodilator. Importantly, as noted by Judge Levin and upheld by the Board, ventilatory testing before and after use of a bronchodilator remained disabling. Therefore, under the specific facts of this case, it is reasonable that the miner's respiratory ailment was the product of more than one disabling process, including coal workers' pneumoconiosis. The Fourth Circuit issued a similar holding in *Swiger* and stated the following:

> All of the experts agree that pneumoconiosis is a fixed condition and therefore any lung impairment caused by coal dust would not be susceptible to bronchodilator therapy. In this case, although Swiger's condition improved when given a bronchodilator, the fact that he experienced a disabling residual impairment suggested that a combination of factors was causing his pulmonary condition. As a trier of fact, the ALJ 'must evaluate the evidence, weigh it, and draw his own conclusions.' (citation omitted) Therefore, the ALJ could rightfully conclude that the presence of the residual fully disabling impairment suggested that coal mine dust was a contributing cause to Swiger's condition. (citation omitted).

Consequently, to the extent that Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino rely on the partial reversibility of the miner's pulmonary function testing to conclude that coal workers' pneumoconiosis is not present, their reports are less probative. The undersigned concludes that presence of a residual disabling impairment that worsened over time is consistent with the presence of legal coal workers' pneumoconiosis.

While the undersigned notes that extensive coal mine employment does not compel a finding that such employment contributed to the development of a miner's respiratory disease, it is incumbent upon the medical experts to provide an adequate explanation regarding causation. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984) (an unsupported medical conclusion is not a reasoned diagnoses). In this light, the opinions of Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino, that the miner's progressively deteriorating and disabling obstructive lung disease was due solely to tobacco abuse with no persuasive explanation excluding contribution of the miner's 27 years of exposure to coal dust, carry little probative value.

On the other hand, the opinions of Drs. Forehand and Paranthaman, that the miner suffers from a smoking-induced and coal dust-induced respiratory impairment, are well-reasoned and well-documented. Initially, it is noted that the Board questioned whether Dr. Paranthaman's diagnosis of coal workers' pneumoconiosis was too equivocal to sustain Claimant's burden. In this vein, the Board noted that, in his November 1995 report, Dr. Paranthaman stated that "[i]f 27 years of coal mine employment is documented, it could have aggravated the condition significantly." On its face, this does appear to be an equivocal diagnosis. However, by supplemental report dated January 19, 1996, Dr. Paranthaman reiterated the negative chest x-ray findings, but unequivocally diagnosed the presence of legal coal workers' pneumoconiosis.

Based on the miner's symptoms and testing, he opined that, while tobacco abuse was the primary cause of the miner's pulmonary emphysema, the miner's lengthy history of coal dust exposure also contributed to development of the condition. Therefore, the undersigned finds that Dr. Paranthaman's opinion is not equivocal and it is well-reasoned and well-documented because it is based on an examination and testing of the miner.

Similarly, Dr. Forehand's opinion, which is also based on examination and testing of the miner, is well-reasoned and well-documented. Although Dr. Forehand found an x-ray study to be positive for the presence of pneumoconiosis, he also noted that the spirometry demonstrated an irreversible ventilatory pattern, which is consistent with a diagnosis of pneumoconiosis.

Drs. Paranthaman's and Forehand's diagnoses of chronic obstructive lung disease and pulmonary emphysema are consistent with the findings of a preponderance of the physicians of record. The fact that Drs. Paranthaman and Forehand attribute development of these conditions to the miner's extensive coal mining and smoking histories is reasonable. Their findings are supported by the irreversible, disabling component of the miner's lung impairment as demonstrated through ventilatory testing. Moreover, their diagnoses are supported by the qualifying blood gas study evidence of record. *Morgan v. Bethlehem Steel Corp.*, 7 B.L.R. 1-226 (1984) (while blood gas studies are relevant primarily to the determination of the extent of impairment, such evidence may bear on the existence of pneumoconiosis insofar as test results indicate the presence of a disease process and, "by implication", the presence of a disease arising out of coal mine employment). The undersigned is also persuaded by studies cited by Dr. Forehand that coal dust exposure as well as tobacco abuse causes obstructive lung disease and pulmonary or centrilobular emphysema and, as previously noted, their premise is consistent with the Department's position in its comments to the amended regulations. *See also Rowan, supra; Summers, supra*.

Finally, it is noted that Drs. Dahhan, Sargent, Tuteur, Castle, Fino, and Paranthaman are board-certified in internal medicine and pulmonary medicine. Dr. Paranthaman is also board-certified in critical care medicine. Dr. Morgan is certified in internal medicine by the Royal College of Physicians in London. Dr. Forehand is board-certified in pediatrics and immunology and allergies[4] and, as with certain other physicians of record, he is a NIOSH certified B-reader. Pursuant to the Board's directive, the undersigned has taken note of the qualifications of the physicians in this record. It is determined that all of these physicians except Dr. Forehand are highly qualified to render opinions regarding the existence and etiology of the miner's respiratory impairment. Although Dr. Forehand's board certifications are not in the area normally associated with diagnosing and treating coal dust-induced respiratory ailments, his opinion is well-documented and well-reasoned on this record and is consistent with Dr. Paranthaman's opinion. For reasons previously set forth in this *Decision*, the probative value placed on each physician's opinion stems from its underlying documentation and reasoning and the undersigned is not persuaded that the relative qualifications of these physicians compel a different result.

[4] Although Dr. Forehand's *curriculum vitae* is not in the record, the undersigned takes judicial notice of his board-certification through the American Medical Association's Directory of Medical Specialties at www.abms.org.

II
Weighing evidence together under *Compton*

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), the court held that, in order to establish pneumoconiosis, all evidence submitted under 20 C.F.R. § 718.202 (2001) must be weighed together. Specifically, the undersigned is required to compare chest x-ray findings under § 718.202(a)(1) with medical opinion findings under § 718.202(a)(4) to determine whether Claimant has sustained her burden.

In this particular claim, the undersigned finds no clinical pneumoconiosis present as the preponderance of the chest x-ray evidence was negative for presence of the disease. However, based on the reports of Drs. Paranthaman and Forehand, as supported by a preponderance of the medical data, *i.e.* qualifying blood gas studies and disabling ventilatory function testing that was only partially reversible, the undersigned is persuaded that the miner suffers from legal coal workers' pneumoconiosis. All of the physicians agree that the miner had chronic obstructive pulmonary disease and emphysema. Drs. Forehand and Paranthaman reasonably attribute these conditions to the miner's extensive coal mine employment and smoking histories. Their opinions are based on testing, symptoms, observations, and certain medical literature.

While a determination of whether a miner's respiratory disease arose from his coal dust exposure must be determined in each claim based on expert medical evidence, it is incumbent upon the medical experts to provide well-reasoned, well-documented opinions. The miner had a 27 year history of coal mine employment and ceased working in 1995. He had a 30 or more pack year history of smoking cigarettes and quit in 1986. Both of these potential causative factors are extensive. Therefore, the undersigned is not persuaded by opinions based on a premise that simple coal workers' pneumoconiosis generally does not cause obstructive lung disease, emphysema, or chronic bronchitis. Moreover, it is insufficient to cite to the partial reversibility of the miner's ventilatory testing in this particular case given that he still demonstrated disabling impairment even after use of a bronchodilator. More explanation is required based on the specific circumstances in this case, particularly in light of the fact that the miner's respiratory impairment progressively worsened over time as evidenced by blood gas and pulmonary function testing, his worsening symptoms of shortness of breath appeared to start after he quit smoking but before he quit coal mine work, and he had significant coal mining and tobacco abuse histories.

The opinions of Drs. Forehand and Paranthaman are based on grounds consistent with the Department's position, *i.e.* that coal dust exposure can cause obstructive lung disease, including emphysema. They properly take into account the miner's symptoms as well as the extensive work and smoking histories established on this record. Drs. Forehand and Paranthaman reasonably conclude that smoking and coal dust exposure contributed to the miner's severe, progressive obstructive lung disease. Their opinions are well-documented by the miner's consistent symptoms of productive cough and exercise intolerance as well as wheezing and other breath sounds noted by Drs. Dahhan, Sargent, and Paranthaman on examination. Even though certain physicians, such as Dr. Tuteur, stated that the miner's symptoms waxed and waned consistent with smoking-induced lung disease, the undersigned reiterates that some symptoms may have waxed and waned, but other symptoms progressively worsened over time. This

constitutes further support that the miner suffered from a combination of respiratory diseases, including coal workers' pneumoconiosis. Based on the foregoing, preponderantly negative chest x-ray findings do not detract from findings of legal coal workers' pneumoconiosis.

On balance, after weighing all of the evidence under 20 C.F.R. § 718.202(a)(1) and (a)(4) (2001), Claimant has established that he suffered from legal coal workers' pneumoconiosis.

III
Cause of total disability

All of the physicians of record conclude that the miner's respiratory impairment is totally disabling. Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino opined that the disability is due to tobacco abuse. Because, as noted by the Board, these physicians failed to diagnose the presence of clinical or legal pneumoconiosis, their opinions are less probative with regard to the cause of the miner's disability. *Scott v. Mason Coal Co.*, 289 F.3d 263 (4th Cir. 2002) (it is proper to discredit the opinions of physicians regarding the cause of disability where they concluded that the miner did not suffer from coal workers' pneumoconiosis contrary to the administrative law judge's findings). Some of these physicians opine that, even if coal workers' pneumoconiosis was established, their opinions as to the cause of the miner's total disability would not change. Even with this premise, their reports are not well-reasoned and carry little probative value. *See Scott, supra.* In *Soubik v. Director, OWCP*, ___ F.3d ___, Case No. 03-1668 (3rd Cir. Apr. 30, 2004), the court held that a physician's failure to diagnose the presence of coal workers' pneumoconiosis would have an adverse effect on his ability to assess whether the miner's death (or disability) was due to the disease:

> Common sense suggests that it is unusually exceedingly difficult for a doctor to properly assess the contribution, if any, of pneumoconiosis to a miner's death if he/she does not believe it was present.

Similarly, in this case, Drs. Dahhan, Sargent, Tuteur, Castle, Morgan, and Fino do not provide a well-reasoned, well-documented opinion that coal workers' pneumoconiosis did not contribute to the miner's disability.

Drs. Forehand and Paranthaman, on the other hand, diagnosed the presence of totally disabling obstructive impairment arising from tobacco abuse and coal dust exposure. As previously noted, their opinions are well-documented and well-reasoned and based on a premise that the miner suffered from coal workers' pneumoconiosis, which is consistent with the undersigned's findings on this record. *See Scott, supra*.

As a result, a preponderance of the evidence supports a finding that the miner suffered from a totally disabling respiratory impairment arising from tobacco abuse and coal dust exposure. 20 C.F.R. § 718.205 (2001).

IV
Onset for payment of benefits

Claimant is entitled to benefits commencing on the date the medical evidence first establishes that he became totally disabled due to pneumoconiosis or, if such a date cannot be determined from the record, the month in which the miner filed his claim which, in this case, is September 1995. 20 C.F.R. § 725.503 (2001); *Carney v. Director, OWCP*, 11 B.L.R. 1-32 (1987); *Owens v. Jewell Smokeless Coal Corp.*, 14 B.L.R. 1-47 (1990). Moreover, as noted by the Board, the date of the first medical evidence of record indicating total disability due to pneumoconiosis does not necessarily establish the onset date; rather, such evidence only indicates that the miner became totally disabled due to the disease at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1306, 1-1310 (1984).

All of the physicians of record conclude that the miner suffers from a totally disabling respiratory impairment. Dr. Paranthaman's January 1996 report is the earliest report of record establishing that the miner is totally disabled due, in part, to coal workers' pneumoconiosis. The testing and findings underlying this opinion relate back to Dr. Paranthaman's November 1995 examination of the miner. There is no medical evidence after the miner filed his claim in September 1995 and Dr. Paranthaman's examination in November 1995 demonstrating that the miner was not totally disabled or that he did not suffer from pneumoconiosis. Given the qualifying ventilatory and blood gas testing during the November 1995, it is reasonable to find that the miner's coal dust and smoking induced respiratory impairment had progressed to the point of becoming totally disabling at some prior point in time.

Because the onset date cannot be determined from the medical evidence, benefits are payable from September 1995, the month in which the miner's claim was filed. Accordingly,

ORDER

IT IS ORDERED that Employer shall pay to Claimant, Jackie W. Clendenon, all benefits to which he is entitled commencing as of September 1995, the month in which Claimant filed for benefits; and

IT IS FURTHER ORDERED that, on or before September 17, 2004, Claimant's counsel shall file, with this Office and with opposing counsel, a petition for a representatives' fees and costs in accordance with the regulatory requirements set forth at 20 C.F.R. § 725.366 (2001). Counsel for the Director and for Employer shall file any objections with this Office and with Claimant's counsel on or before October 1, 2004. It is requested that the petition for services and costs clearly state (1) counsel's hourly rate and supporting argument or documentation therefor, (2) a clear itemization of the complexity and type of services rendered, and (3) that the petition contains a request for payment for services rendered and costs incurred before this Office only as the undersigned does not have authority to adjudicate fee petitions for work

performed before the district director or appellate tribunals. *Ilkewicz v. Director, OWCP*, 4 B.L.R. 1-400 (1982).

A

JOHN M. VITTONE
Chief Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.